Envoy Medical Systems, LP
4500 Cumbria Lane
Austin, TX 78727

PH: (512) 705-4647
FAX: (512) 491-5145
IRO Certificate #4599

DATE OF REVIEW: 5/15/15

IRO CASE NO.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Shoulder Arthroscopy, Rotator Cuff Repair; CPT: 29826, 29827

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
Physician Board Certified in Orthopedic Surgery

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld	(Agree)
Overturned	**(Disagree) X**
Partially Overturned	(Agree in part/Disagree in part)

PATIENT CLINICAL HISTORY SUMMARY
An office note from dated 4/21/15 was reviewed; it is a request for reconsideration. It states that the patient under went two supracromial cortisone injections by the orthopedic surgeon treating her. She also completed 10 physical therapy sessions. The note states that her physical exam is consistent with rotator cuff tears as documented by pain, weakness and positive impingement test.

Clinical notes were reviewed. (Dated from 10/20/14 through 4/10/15). Other notes do document her complaints, exam and treatment, thus far.

Clinical notes were reviewed. His first note is dated 12/02/14. Patient presented with right shoulder pain, severity graded 7/10. Note states pain began after she was pushing a cart and fell. Physical exam shows tenderness of the greater tuberosity and bicipital groove. She was noted to have right shoulder forward flexion of 90 degrees and passive forward flexion of 160 degrees. Her Hawkins test was positive. There was no instability. Muscle strength test revealed supraspinatus weakness graded 4/5. Sensory examination was normal. His notes mention the MRI report shows a full vs partial thickness supraspinatus tear without retraction. Supracromial cortisone injection was performed.

saw the patient again on 1/09/15. She continues to have shoulder pain and popping. Another cortisone injection was performed to the right supracromial space

PATIENT CLINICAL HISTORY SUMMARY (continuation)
The patient was instructed on home exercises for strengthening, including using therabands. She is to continue with her strengthening program.

Patient saw on 2/23/15 and yet again on 3/23/15. She continues to have pain and weakness. Active forward flexion was 165 degrees. Supraspinatus strength was graded 4/5. He recommended she follow up with primary physician and obtain a second opinion to try to obtain surgical approval.

MRI report, right shoulder, dated 10/27/14 shows ACJ arthritis with small effusion, partial thickness, supraspinatus tear, small effusion in the bursa, and moderate effusion at the glenohumeral joint.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION

Opinion: I disagree with the benefit company's decision to deny the requested service of arthroscopic rotator cuff repair. Rationale: Based on my review of the records, I disagree with the benefit company's decision to deny the requested service of arthroscopic rotator cuff repair. Rationale:The patient clearly has physical exam and radiographic findings of a rotator cuff tear. She remains symptomatic after a sufficient length of physical therapy and two cortisone injections.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

ACOEM-AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGE BASE

AHCPR-AGENCY FOR HEALTH CARE RESEARCH & QUALITY GUIDELINES

DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

INTERQUAL CRITERIA

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE & EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS X

MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

MILLIMAN CARE GUIDELINES

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES X

PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

TEXAS TACADA GUIDELINES

TMF SCREENING CRITERIA MANUAL

PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE DESCRIPTION)